Reducing health inequalities through general practice: a realist review and action framework

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Scientific summary

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Background

Socio-economic inequalities in health have been in the public health discourse and policy agenda for decades. There is ample evidence showing that inequalities in premature mortality are mainly driven by inequalities in chronic diseases and especially cancer, cardiovascular and respiratory disease. In the most deprived areas of the country, patients with cardiovascular disease (CVD) deal with a four times higher possibility of premature death than patients in the least deprived areas. In this context, general practice as the front door to the healthcare system has an important role to play in reducing inequalities especially when it comes to chronic conditions. The COVID-19 pandemic has highlighted both the range of health inequalities and the importance of general practice in addressing and tackling the problem. However, it has also revealed chronic deficiencies of the sector which combined with the pressure during the pandemic have resulted in a physically and emotionally exhausted workforce and greater scarcity of resources. In this climate, there is an urgent need for action to secure general practice's future as more equitable and effective for its patients, their families and carers, but also for its workforce.

Objectives

Our study explored what types of interventions and aspects of routine care in general practice decrease or increase inequalities in healthcare and outcomes among people with or at risk of CVD, cancer, diabetes and/or chronic obstructive pulmonary disease, and for whom these interventions and aspects of care work best, why, and in what circumstances. Our main objective was to synthesise this evidence to produce specific guidance for healthcare professionals and decision-makers about how best to tackle health inequalities in general practice.

Methods

We conducted a realist review following Pawson's five iterative steps: (1) locating existing theories, (2) searching for evidence, (3) selecting articles, (4) extracting and organising data and (5) synthesising the evidence. We started with an exploratory literature search and discussions with experts in the field, to identify existing theories that explain how, for whom, why and in what circumstances interventions or care delivered in general practice may increase or decrease health inequalities. Next, we conducted a literature review in two steps. First, we conducted an initial search of systematic reviews of interventions delivered in general practice and focused on CVD, cancer, diabetes and/or chronic obstructive pulmonary disease (COPD) across the Medical Literature Analysis and Retrieval System Online, Excerpta Medica Database, Cumulative Index to Nursing and Allied Health Literature, Psychological Information Database, the Web of Science and the Cochrane Library. Second, we extracted all the primary studies included in the systematic reviews which met our inclusion criteria, and we screened them searching for interventions which reported on clinical outcomes or care-related outcomes by socio-economic group, or other PROGRESS-Plus criteria. To be able to review the included studies within the study timeline, we combined steps 3 and 4, so the selection of articles took place at the same time with the data extraction.

The data synthesis followed a realist logic which suggests that outcomes are the results of specific causal mechanisms which are triggered only within specific contexts. Accordingly, we combined the evidence into statements of causal relationships (what in realist terms are called context–mechanism–outcome configurations) which connect a context with an outcome through an underlying mechanism.

Results

We identified 7998 review studies, of which 251 met the inclusion criteria. From the included reviews, we retrieved 6555 primary studies and proceeded with a second round of screening. In total, 325 studies met the inclusion criteria for primary studies and were grouped into three categories: those focusing primarily on inequalities (*n* = 56), those focusing on an intervention, or an aspect of care targeted at specific disadvantaged groups (*n* = 137) and those assessing the impact of an intervention without focusing on inequalities but accounting for one or more PROGRESS-Plus criteria (*n* = 132). The studies involved a wide range of designs, with almost half of them being randomised controlled trials or other experimental design (*n* = 157).

Our review revealed that there is limited research on interventions that aim to decrease inequalities in general practice or evidence about the effect of general practice interventions by PROGRESS-Plus criteria. Given the diversity of the included articles and the lack of in-depth information, instead of specific characteristics of interventions we focused on the underlying principles that informed care and interventions and the ways they can be employed to achieve equitable care in general practice. We found that in order to decrease inequalities general practice needs to be connected (i.e. programmes and interventions should be coordinated across the sector), intersectional (i.e. care should account for the fact that people's experience is affected by many of their characteristics like their gender and socio-economic position), flexible (i.e. care should meet patients' different needs and preferences), inclusive (i.e. care should not exclude people because of who they are) and community-centred (i.e. working with the people who will receive care when designing and providing it).

These five qualities of equitable general practice should be employed to inform action across four different domains of power organisation. In the structural domain action should focus on funding allocation, workforce size and diversity, premises convenience and pre-existing inequalities in the social determinants of health (SDH). In the cultural domain action should focus on integrating an understanding of patient worldviews, beliefs and values, and developing culturally sensitive communication and educational material. Moreover, action in the cultural domain should involve shifting away from designing educational or training interventions outside the social and cultural context of patients. Finally, it should involve tackling biases among general practice staff (clinical and non-clinical). In the disciplinary domain, which involves regulated procedures taking place in the everyday delivery of care, action should focus on how disadvantaged patients are excluded from quality assessment standards, and the effective collection and use of patient socio-demographic information, especially socio-economic status and ethnicity, in risk assessment and quality evaluation. Further, emphasis should be put on invitation methods to prevention services, the working hours of services and the contact time between patients and healthcare staff, continuity of care, as well as on the employment of multidisciplinary care teams and the support of all members of staff to engage in prevention services for disadvantaged patients. Finally, in the interpersonal domain, empathetic and trusting relationships between patients and healthcare staff and personalised communication should be a special focus for services. Further, balanced relationships among staff members across professional hierarchies and mutual respect for each other's leadership skills is another meaningful area of action.

Conclusions

Inequalities in general practice result from complex processes and power imbalances across four different domains that include structures, ideas, regulations and bureaucracies, and relationships among individuals and communities. To achieve equity, general practice needs to be connected, intersectional, flexible, inclusive and community-centred and effective action implies:

1. Creating a positive vision for general practice. Policy-makers may find it helpful to work on a positive vision of what equitable general practice looks like. It is recommended that reducing health

inequalities remains high in the policy-makers agenda and solutions are planned based on a long-term perspective and the integration of different policy domains, including social policy. This among others requires involving front-line workers in general practice and disadvantaged groups in the development of a health-inequality-related strategy.
2. Making effective use of diversity to promote equity in care outcomes. This among other things could involve tackling structural racism and sexism; inclusion work covering sexual orientation, disability, religion and caring responsibilities; cultivating a less Western-centric organisational culture; including social-sciences and humanities modules in medical training; and increasing cultural competence at the practice level with the recruitment and progression of local clinical and non-clinical staff.
3. Workforce support so that staff are recruited and retained in disadvantaged and remote areas. This can be achieved through providing additional training for less experienced employees; financial and career development incentives in disadvantaged and rural areas; medical school placements; developing a subspecialty related to providing care in highly socio-economically disadvantaged areas; and providing training to nurses, healthcare assistants and administrative staff to improve the overall capacity of practices and also staff experience.
4. Equitable distribution of funding so that it accounts better for differences in need of the served populations. This among other things can take the form of updating the Carr-Hill formula so that it integrates patient socio-economic status and ethnicity and higher patient list weights for practices in disadvantaged areas.
5. Tackling accessibility barriers. This can take the form of co-locating practices with local services such as foodbanks or citizens' advice offices; locating services close to community landmarks such as schools, libraries and cultural or recreational centres; contributing to the development of community transport options; providing targeted home visits; and remote consultation options.
6. Investing in collecting and disaggregating high-quality data by social/socio-demographic categories, such as socio-economic group, or ethnicity. This among other things could involve securing the necessary time for data collection and update during or around consultation time; making data collection and maintenance a specific part of the professional role of clinical and non-clinical staff; and making the best use of IT resources for the development of accurate and up-to-date patient registers.
7. Increasing continuity of care for long-term conditions and patients with complex health problems and social circumstances. This can be achieved through improving working conditions and providing incentives (e.g. financial, training, social) for staff to remain in their post; focusing on continuity between micro-teams and patients instead of individual general practitioners (GPs) and patients; and involving GP teams in invitations to prevention services.
8. Balancing autonomy to facilitate local community-oriented solutions with standardised care. Local general practices need relative autonomy to decide how to do their work better in terms of reducing inequalities. This can involve increased consultation time for patients with complex needs; translation services specific to the needs of the served population; working hours that work better for the community; and the use of community spaces for the delivery of care and promotion of services.

Future research should

1. Prioritise inequalities and apply a health-inequalities perspective to broader research and evaluation work.
2. Systematise evidence on health inequalities and develop platforms which will allow easy and effective access to the evidence.
3. Re-consider the effectiveness of PROGRESS-Plus criteria and their suitability as dimensions of inequality.
4. Integrate and operationalise intersectionality.

5. Use qualitative and mixed-methods approaches to provide detailed information about the transferable evidence-based principles behind specific interventions and upstream drivers of inequalities in SDH.
6. Focus more on conditions intrinsically associated with disadvantage, such as COPD, and specific models of local general practice which are designed to address inequalities.
7. Focus on the cultural domain and explore the interconnection(s) between structural racism, healthcare worker and patient experiences of discrimination, and care outcomes in general practice.

Study registration

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